Postpartum Depression
A Cause for Concern

Demographics of Postpartum Depression (PPD)

The most common complication of pregnancy [1-3]
- Occurs in 10% - 20% of all pregnancies [1-3]
- Impacts approximately 1 in 8 women [1-3]

May effect more than 10,000 women a year in Utah [4]

There is a three-fold increase in the rate of onset of depression following delivery, generally within the first four weeks postpartum but it can be as late as several months [5]

Risk Factors for PPD

History of prior mental illness [6]

Previous episode of PPD [6]

Poor social support [2, 7]

Economic burdens [2, 7]

Impact of PPD

Potential for suicide [8]

Disruption of normal development in infants of mothers with PPD, including -
- Behavioral problems [9-11]
- Delayed cognitive development [9-11]
- Impaired social development [9-11]
- Insecure attachment patterns [9-11]

Screening

PPD often goes unrecognized [1-3]

Screen during both antepartum and postpartum periods [6, 12]

Utilize a well validated tool such as the Edinburgh Postnatal Depression Scale (EPDS) [1, 13-17]

Treatment of PPD

Counseling/psychotherapy with a psychologist or social worker is effective [1, 3, 6]

Hormonal therapy has been shown to be effective, although not as well studied as counseling and antidepressant medications [1, 3, 6]

Antidepressants have been shown to improve symptoms. Consider starting at one half the normal starting dose in a postpartum woman [1, 3, 6]

Antidepressants and Breastfeeding

The following recommendations are based on literature review.[1, 3, 6, 18] Use the lowest therapeutic dose to prevent any possible adverse reactions to the infant.

1st line agents: Drug not detected to extremely low drug levels in infant's serum. No adverse reactions reported. Minimal side effects experienced by the mother.

-Sertraline *(Zoloft)* 25-200mg po qd. Start at 25mg po qd and increase gradually.

-Paroxetine *(Paxil)* 10-40mg po qd. Start at 10mg po q am and increase gradually.

2nd line agents: Drug not detected to extremely low drug levels in infant's serum. No adverse reactions reported. Increased side effects experienced by the mother.

-Nortriptyline *(Pamelor)* 25-150mg po q hs. Start at 25mg po q hs and increase gradually.

-Desipramine *(Norpramin)* 50-200mg po q am. Start 25mg po q am and increase gradually.

3rd line agents: Low levels of drug detected in infant's serum. One report of extreme colic and infant fussiness, which resolved upon discontinuation of citalopram.

-Citalopram *(Celexa)* 10-60mg po qd. Start at 10mg po qd, increase q week.

-Venlafaxine *(Effexor)* 37.5-75mg po bid or tid. Start at 37.5mg po bid and increase by 37.5-75mg q 4-7days to a maximum of 375mg.

Unknown: Have not been studied extensively.

-Bupropion *(Wellbutrin)*

-Mirtazipine *(Remeron)*

-Escitalopram *(Lexapro)*

Caution: Adult therapeutic levels detected in infant serum. A clinic trial has shown decreased weight gain in infants. Also, poor sleep, agitation and general infant fussiness have been reported.

-Fluoxetine *(Prozac)*

If a woman wishes to stop taking her antidepressants, warn her to withdraw slowly.

For further information, contact the Pregnancy RiskLine: In Salt Lake City at 328-BABY (2229). Outside Salt Lake City 1-800-822-BABY (2229).

References

1. Wisner, K.L., B.L. Parry, and C.M. Piontek, *Clinical practice. Postpartum depression.* N Engl J Med, 2002. **347**(3): p. 194-9.
2. Yonkers, K.A., et al., *Onset and persistence of postpartum depression in an inner-city maternal health clinic system.* Am J Psychiatry, 2001. **158**(11): p. 1856-63.
3. Gjerdingen, D., *The effectiveness of various postpartum depression treatments and the impact of antidepressant drugs on nursing infants.* J Am Board Fam Pract, 2003. **16**(5): p. 372-82.
4. *Pregnancy Risk Assessment and Monitoring Survey (PRAMS) Data*. 2001, Utah State Department of Health, Reproductive Health Program: Salt Lake City.
5. Cox, J.L., D. Murray, and G. Chapman, *A controlled study of the onset, duration and prevalence of postnatal depression.* Br J Psychiatry, 1993. **163**: p. 27-31.
6. Brockington, I., *Postpartum psychiatric disorders.* Lancet, 2004. **363**(9405): p. 303-10.
7. Baker, D. and H. Taylor, *The relationship between condition-specific morbidity, social support and material deprivation in pregnancy and early motherhood. ALSPAC Survey Team. Avon Longitudinal Study of Pregnancy and Childhood.* Soc Sci Med, 1997. **45**(9): p. 1325-36.
8. Oates, M., *Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality.* Br Med Bull, 2003. **67**: p. 219-29.
9. Murray, L., et al., *The cognitive development of 5-year-old children of postnatally depressed mothers.* J Child Psychol Psychiatry, 1996. **37**(8): p. 927-35.
10. Chaudron, L.H., *Postpartum depression: what pediatricians need to know.* Pediatr Rev, 2003. **24**(5): p. 154-61.
11. Weinberg, M.K.T., E.Z., *The impact of maternal psychiatric illness on infant development.* J Clin Psych, 1998. **59**(suppl 2): p. 53-61.
12. Wisner, K.L., et al., *Prevention of recurrent postpartum depression: a randomized clinical trial.* J Clin Psychiatry, 2001. **62**(2): p. 82-6.
13. Cox, J.L., J.M. Holden, and R. Sagovsky, *Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale.* Br J Psychiatry, 1987. **150**: p. 782-6.
14. Eberhard-Gran, M., et al., *Review of validation studies of the Edinburgh Postnatal Depression Scale.* Acta Psychiatr Scand, 2001. **104**(4): p. 243-9.
15. Stuart, S., et al., *Postpartum anxiety and depression: onset and comorbidity in a community sample.* J Nerv Ment Dis, 1998. **186**(7): p. 420-4.
16. Brouwers, E.P., A.L. van Baar, and V.J. Pop, *Does the Edinburgh Postnatal Depression Scale measure anxiety?* J Psychosom Res, 2001. **51**(5): p. 659-63.
17. Chaudron, L.H., et al., *Detection of postpartum depressive symptoms by screening at well-child visits.* Pediatrics, 2004. **113**(3 Pt 1): p. 551-8.
18. Burt, V.K.S., R. Altshuler, l. Stowe, Z. Hendrick, V.C. Muntean, E., *The use of psychotropic medications during breast-feeding.* Am J Psychiatry, 2001. **158**: p. 1001-1009.

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